Noble (C. P.)

[Reprinted from the AMERICAN GYNÆCOLOGICAL AND OBSTETRICAL JOURNAL for May, 1896.]

A NEW OPERATION FOR CERTAIN CASES OF PROCIDENTIA UTERI.*

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The operations usually done for procidentia uteri, in my hands, have yielded very satisfactory results. For some years I treated these cases by amputation of the cervix, anterior colporrhaphy, and perineorrhaphy. Of the cases operated upon in this way, in only one did the uterus again markedly prolapse. In some of them, however, especially when the uterus was retroverted, it would sink enough in the pelvis to cause dragging sensations, and also to favor the formation of a small cystocele. The percentage of cases, however, in which even this partial failure was observed, was quite small. I have myself operated a second time but once in all cases operated upon by the method described. In one other case the operation was a complete failure.

During the past few years, in addition to the operations formerly done, when the uterus was markedly retroverted, and in all cases in which procidentia was marked, I have done a hysterorrhaphy. Of these cases, so far as I know, a cure has been obtained in all but one. Not only have the cases not returned to me for further treatment, but also I have failed to hear of them as being in the hands of the various other gynæcologists in the city.

These general remarks are made to show that I feel that the average case of procidentia can be satisfactorily dealt with by the operations heretofore in use for the treatment of this condition. Failure to obtain good results, as a general statement, in my judgment, is due to the application of the operations rather than to the operations

* Read before the Philadelphia Obstetrical Society, March 5, 1896.

themselves. There is a class of cases, however, to which these remarks do not apply. I refer to those cases of complete or partial procidentia, in which the vagina is stripped off from the rectum and Douglas' pouch is deepened down to or near the anus. Intra-abdominal pressure in these cases can act very much more disadvantageously than in those cases in which Douglas' pouch occupies its normal plane, and therefore the probabilities of recurrence after operation are much greater than in the more usual cases of procidentia. As illustrating this point, I will report the case of Mrs. B., who consulted me first in November, 1894. Her age is forty-seven and she is the mother of seven children. For twenty-three years she has had falling of the womb, and for twenty years complete procidentia. On examination, the uterus was found completely prolapsed, protruding from the vulva. The vagina also was turned completely inside out, and a large cystocele was present. The posterior vaginal wall was stripped away from the rectum down to the anus, and the lateral vaginal walls likewise were stripped away from their normal attachments. On February 9, 1895, I operated upon her by amputating the cervix and performing anterior colporrhaphy, perineorrhaphy, and hysterorrhaphy. She made a good recovery from her operation. The result from the perineorrhaphy, it should be said, was not as good as is usually obtained. Mrs. B. was much improved for a time, and the uterus remained in the pelvis. It was not long, however, after she resumed her usual occupation before the posterior wall of the vagina bulged forward, dragging upon the cervix, which in time elongated sufficiently to protrude from the vulva, although the fundus remained attached to the abdominal wall. It was evident that a more radical procedure was necessary to cure this patient. On January 25, 1896, I reopened the abdomen and did a hysterectomy after the method used in dealing with fibroids. The cervical stump was sewed up, and it, together with the stumps of the broad ligaments, was covered over with the bladder peritonæum. The remaining portion of the cervix was then anteverted, and the posterior wall of the cervix was sewed to the abdominal wall. As the attachments of the vagina to this part of the cervix are very intimate, it practically amounted to sewing the vagina to the abdominal wall, without having the disadvantage of opening into this canal. A careful examination of Douglas' pouch showed that it was deepened almost to the anus. On February 20th lateral colporrhaphy and perineorrhaphy were done. Mrs. B. has made a good recovery from these operations and has a very firm perinæum.

I report this method of dealing with this class of cases as a distinct advance on the methods heretofore in use, recognizing, however, that the abnormal deepening of the pouch of Douglas has not been remedied, and that therefore intra-abdominal pressure may again cause the posterior wall of the vagina to bulge forward. In that case the only thing additional which can be done is to cut through the vault of the vagina behind the cervix and pack the pelvis wi'h gauze, with the object of obliterating Douglas' pouch by the formation of adhesions. I wish to offer the operation reported herewith, and the suggestion of the packing of the pelvis with gauze, as a contribution to the treatment of this particular class of cases of procidentia.